

**BLUE CROSS OF CALIFORNIA  
MEMBER RESPONSIBILITY AGREEMENT**

Member Name: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Provider: \_\_\_\_\_

Provider Tax ID: \_\_\_\_\_ Phone: \_\_\_\_\_

I agree to pay provider for those non-covered (i.) services, (ii.) number of days of service, (iii.) products and/or, (iv.) product upgrades specified below which are not covered under my Benefit Agreement.

I also understand that I am responsible for the difference between the covered expense for covered services and the total cost for services listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility.

<u>SERVICE, PRODUCT OR UPGRADE</u>	<u>TOTAL COST</u>	<u>COVERED EXPENSES</u>	<u>MEMBER'S RESPONSIBILITY</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\_\_\_\_\_  
Member/Subscriber Signature

\_\_\_\_\_  
Date Signed

I (Provider) certify that the Member/Subscriber will be billed and held responsible only for applicable co pays and deductibles for covered services, and for the difference between the covered expense for covered services and the total cost for services listed above which were determined by Blue Cross, and/or it's affiliates, to be non-covered services under Member's Benefit Agreement.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date Signed

***“To be effective and valid, this document must be executed prior to the delivery of any non-covered (i.) services, (ii.) number of days of service, (iii.) products and/or, (iv.) product upgrades”.***